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No. 88-1530

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1988

JOSEPH V. JULIANO,
Petitioner,
vs.
COMMERCIAL LIFE INSURANCE COMPANY
and AUTOMATIC DATA PROCESSING, INC.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE CALIFORNIA SUPREME COURT

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF
AMICUS CURIAE AND BRIEF AMICUS CURIAE

CALIFORNIA MEDICAL ASSOCIATION

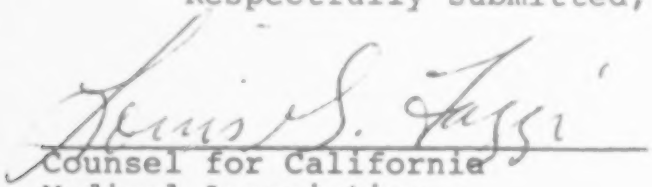
hereby respectfully moves for leave to file the attached Brief Amicus Curiae in this case. The consent of the attorney for the petitioner has been obtained. The consent of the attorney for the respondent was requested but refused.

The interest of the CALIFORNIA MEDICAL ASSOCIATION in this case arises from the fact that ERISA preemption of state law remedies for the failure of an

insurance company to pay a medical claim may have a negative effect on the welfare of this association's patients and may substantially increase the cost of medical care in California. Since neither petitioner nor respondent can adequately assess the effect of ERISA preemption of state law remedies under the California Insurance Code as it will affect health care and cost in California, it is believed that the Brief which Amicus Curiae is requesting permission to file will present a more complete argument on these issues.

April 14, 1989

Respectfully submitted,



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AMICUS CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PETITIONER JOSEPH V. JULIANO

INTRODUCTORY STATEMENT

The undersigned Amicus Curiae, CALIFORNIA MEDICAL ASSOCIATION, respectfully submits this Brief in support of Real Party-in-Interest JOSEPH V. JULIANO. The undersigned is concerned with the present case because the undersigned believes that it is absolutely essential to the welfare of

the patients of its members that the laws of the State of California designed to enforce the California Insurance Code and protect such patients remain in full force and effect and not be emasculated and nullified by creating an exemption from these laws by preemption under the Employee Retirement Income Security Act, 29 U.S.C. sections 1001, et seq., (ERISA).

To decree the ERISA preemption sought by COMMERCIAL LIFE INS. CO. will result in serious increases in health care costs, a deterioration of service and serious financial hardship for those citizens and residents of this State who can least afford it--the sick and the disabled. (See Point IA, infra.)

Hereinbelow, we will show that this Court should not sanction such a result, for the following reasons:

1. It was not the intention of Congress to destroy the safeguards and protections afforded by state law for the benefit of the very persons Congress intended to protect by enacting ERISA (Point I, infra);

2. The United States Supreme Court decisions do not require an interpretation of ERISA preemption that would result in a wholesale nullification of all the laws of this State protecting beneficiaries of health care insurance (Point II, infra);

3. California Insurance Code section 790.03(h) is clearly a state law regulating insurance, and as such is exempt from ERISA. See Point III, infra.

I

IT WAS NOT THE INTENTION OF CONGRESS TO DESTROY THE SAFEGUARDS AND PROTECTIONS AFFORDED BY STATE LAW FOR THE BENEFIT OF THE VERY PERSONS CONGRESS INTENDED TO PROTECT BY ENACTING ERISA.

A. ERISA preemption would allow insurers to disregard and ignore important legislation enacted by this State for the welfare of the sick and disabled. Preemption will burden the health care system and cause the public to lose protection vital to necessary health care.

It is not a secret that the desire of the insurance industry to place itself under blanket federal regulation in the present situation is based on the fact that ERISA is not designed to insure prompt payment of legitimate insurance claims, and did not even contemplate this problem. See subsection B, infra. ERISA's civil enforcement provisions, 29 U.S.C. section 1132, provide only that a

civil action may be brought by a participant or beneficiary of an ERISA plan [1/] "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. section 1132(a)(1)(B).

ERISA preemption of state insurance laws permits insurers to delay or deny claims with impunity, the only penalty: pay what the insurance policy required them to pay in the first place and attorneys' fees in the discretion of the

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1 We use the term "ERISA plan" to refer to a plan subject to the provisions of ERISA. Such a plan is defined as an "employee benefits plan" established or maintained by an employer or employee organization engaged in any industry or activity affecting commerce. 29 U.S.C. section 1003(a). Certain plans, such as governmental or church plans, are exempt. 29 U.S.C. section 1003(b). "Employee benefit plan" is defined in 29 U.S.C. section 1002, subdivisions 1 through 3.

court. 29 U.S.C. section 1132(g). In states which regulate insurance by remedies in addition to contract benefits, the effect of the removal of the powerful prod of exposure to state law will be to cause inordinate delay in payment of entirely legitimate medical expenses and, in many instances, outright arbitrary refusal to pay these charges at all. 2/

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2 The preemption issue is also before this Court in Kanne v. Connecticut General Life Ins. Co. Nos. 85-5641 and 85-5642. (9th Cir. 1987) The Kanne case is a typical example of the type of abuses that will become increasingly prevalent in this State if our citizens are restricted to ERISA remedies. Therein, the plaintiffs' infant son had serious medical problems, requiring extensive hospitalization. See opinion of the District Court in Kanne v. Connecticut General Life Ins. Co. 607 F.Supp. 899 (C.D. Cal. 1985). Hospital bills of more the $89,000.00 were incurred, beginning in October 1981 (607 F.Supp. at p. 904). The insurer paid small amounts sporadically, with the result that some $69,000.00 of these bills remained unpaid until October 1982, one year later (607 F.Supp. at p. 906).

Moreover, under ERISA regulations, an insurance company could delay any decision as to whether to pay a claim for up to 300 days. 29 C.F.R. section 2560.503-1(e)(1)(3); section 2560.503-1(h). Thus, an insurer is not even considered in violation of ERISA provisions if it makes a decision on the claim within 10 months after the charges have been incurred. And even if it in

(Footnote 2 continued.)

District Judge Rafeedie, sitting without a jury, found the plaintiffs had sustained $250,000.00 emotional distress damages, and also assessed the insurer with $500,000.00 punitive damages, for breach of the common law duty of good faith and fair dealing and for breach of the Insurance Unfair Practices Act, California Insurance Code section 790.03(h) (607 F.Supp. at p. 910). The Ninth Circuit held under the subsequent decision in Pilot Life Ins. Co. v. Dedeaux 481 U.S. 41, 107 S.Ct. 1549 (1987). The California Insurance Unfair Practices Act was preempted even though the Court assumed the law regulates insurance and ERISA specifically exempts laws which regulate insurance.

fact violates this 10-month provision, it is not subject to any penalties, even the ineffective ERISA penalties. Insofar as we are aware, there is no provision in the statute or the regulations for prompt payment of a claim even if it is not denied or contested. See 29 U.S.C. section 1132; 29 C.F.R. section 2560.503-1.

We do not believe that our health care system can withstand a great number of delays in payment for such inordinate lengths of time, even if payment is ultimately made. Because of the large number of employees in California dependent on ERISA employee benefit plans to pay their bills, the potentially catastrophic effect of ERISA preemption is self-evident, and cannot seriously be denied. If an insurer may legally wait indefinitely to pay benefits, why should

it pay them promptly? The inevitable delays and outright denial of claims for fabricated and pretextual reasons will immeasurably add to the costs and burdens of health care providers, and these added costs and burdens will inevitably be passed on to the public.

Nor is the Insurance Unfair Practices Act the only state law protecting the patient which is threatened with extinction or emasculation by a broad interpretation of ERISA preemption. Numerous other beneficial and protective laws of this State are also threatened by such an interpretation. Some of these laws include the following:

1. Provisions aimed at insuring that non-profit hospital service plans and health care service plans contain adequate financing and reserves.

California Insurance Code sections 11507-11511, Health and Safety Code section 1375.1;

2. Provisions prohibiting insurers from discriminating between individuals because of race, color, religion, national origin or ancestry. California Insurance Code sections 10140, 10141;

3. Provisions prohibiting less favorable terms to employees in group disability insurance plans than to their spouses. California Insurance Code section 10122.2. See also California Insurance Code section 10123.4; Health and Safety Code section 1374;

4. Provisions prohibiting discrimination against physically handicapped persons. California Insurance Code sections 10123.1, 10123.2; Health and Safety Code section 1373(f);

5. Provisions prohibiting

discrimination against persons carrying a gene which causes no adverse effects in the carrier. California Insurance Code sections 10123.3, 10143, 11512.95; Health and Safety Code section 1374.7;

6. Provisions barring exclusion of victims of Alzheimer disease or other dementing illnesses from receiving benefits or other coverage. California Insurance Code sections 10123.16, 10123.17, 11512.177; Health and Safety Code section 1373.14;

7. Provisions barring group disability insurers and health care service plans from discriminating against the blind. California Insurance Code section 10145; Health and Safety Code section 1367.4;

8. Provisions preventing insurers from controlling the patient's selection of a hospital or physician. California

Insurance Code section 10133;

9. Provisions that health care service plans and hospital service plans which affect a patient's freedom of choice in selecting physicians or hospitals must clearly so inform the patient. California Insurance Code sections 10123.12, 11512.176; Health and Safety Code section 1367.10;

10. Provisions requiring health care service plans (which restrict the patient's freedom of choice of providers) to follow a variety or procedures to insure access to quality medical care, such as grievance systems (Health and Safety Code 1368; 10 Cal.Admin. Code section 1300.68); requirements that subscribers participate in formation of plan procedures (Health and Safety Code section 1369, 10 Cal.Admin. Code section 1300.6) and establishment of a quality of

care review system (Health and Safety Code section 1370, 10 Cal.Admin. Code section 1300.70);

11. Provisions requiring that facilities providing the primary health care services of a health care service plan must be located within reasonable proximity of the business or personal residences of enrollees, that the hours of operation and provisions for after-hour services must be reasonable and that emergency health care services must be available and accessible within the service area 24 hours a day, seven days a week. 10 Cal.Admin. Code section 1300.67.2;

12. Numerous provisions mandating that entities providing coverage for health care provide certain benefits, as well as coverage for dependents of the insured or plan participant. Some

examples of mandates include the following:

a. Requirements that coverage continue for certain dependents upon the attainment of the limiting age for dependency. California Insurance Code sections 10277, 10278, 10124; Health and Safety Code section 1374;

b. Requirements of coverage for newborn infants or newly adopted children. California Insurance Code sections 10119, 10121(b), 11512.1; Health and Safety Code section 1373;

c. Coverage requirements for maternity benefits. California Insurance Code section 10119.5, 10121(c), 11512.13; Health and Safety Code section 1373.4;

d. Coverage for conditions attributable to diethylstibestrol or exposure to it. California Insurance Code sections 10119.7, 11512.195; Health

and Safety Code section 1367.9;

e. Coverage requirements for diabetic daycare self-management education programs. California Insurance Code sections 10177.7, 11512.23; Health and Safety Code section 1367.5;

f. Coverage requirements for home health care. California Insurance Code section 11512.20; Health and Safety Code section 1374.10;

g. Coverage requirements for mental or nervous disorders. California Insurance Code sections 10125, 10127, 11512.5; Health and Safety Code section 1373(h);

13. Provisions requiring that coverage must be extended 12 months after discontinuance of a plan or policy for expenses relating to any condition causing total disability. California Insurance Code sections 10128, 10128.2;

Health and Safety Code section 1399.62;

14. Provisions to insure that providers of health coverage provide for an extension of coverage for any period following the termination of the employment of an employee, including dependents of the employee, upon the same terms and conditions precedent as apply to covered employees, for the same period of time. California Insurance Code sections 10122, 10123, 11512.1; Health and Safety Code section 1373;

15. A provision prohibiting a policy of insurance or health plan providing for loss of time benefits to contain any provision for a reduction of those benefits during a benefit period because of an increase in benefits payable under the Federal Social Security Act. California Insurance Code section 10127.1; Health and Safety Code section

1373;

16. Perhaps most importantly, the law of this State requires reimbursement of covered expenses no later than 30 days after receipt of the claim, unless a claim or portion thereof is contested. California Insurance Code sections 10123.13, 11512.180; Health and Safety Code section 1371. .

The foregoing constitute only some of the laws of this State aimed at protecting those of our citizens who may have medical problems requiring the services of physicians and hospitals. We believe that all of them, including the Unfair Practices Act, should be protected from ERISA preemption under the United States Supreme Court decision in Metropolitan Life Ins. Co. v. Massachusetts 471 U.S. 724, 105 S.Ct. 2380 (1985).

We do not know whether the insurance industry will concede that at least some of these provisions are not preempted. Clearly, state law mandated benefits provisions are within the ERISA savings clause and hence are not preempted. Metropolitan Life Ins. Co. v. Massachusetts, supra. These provisions alone establish that ERISA's asserted purpose of providing uniformity does not apply inflexibly. Any attempt to place other provisions within ERISA preemption will result in a situation in which those responsible for enforcing and administering the laws of this State will be unable to determine which laws are enforceable and which are nullified.

As we will now show, in enacting ERISA, Congress had no intention whatever of permitting insurance companies to nullify any of the foregoing

statutes. Of course, in determining preemption issues "(t)he purpose of Congress is the ultimate touchstone." Pilot Life Ins. Co. v. Dedeaux, supra, 107 S.Ct. at p. 1552.

B. Congress had no intention whatever of permitting the evils that would occur from ERISA preemption of state laws which afford urgently needed insurance protection to employees of ERISA welfare benefit plans.

In Metropolitan Life Ins. Co. v. Massachusetts, supra, the United States Supreme Court said:

> "We. . .must presume that Congress did not intend to preempt areas of traditional state regulation."

105 S.Ct. at p. 2389, 471 U.S. at p. 740

> "The presumption is against preemption,. . ."

105 S.Ct. at p. 2390, 471 U.S. at p. 741

It is clear that ERISA was

established for the primary purpose of safeguarding employee pensions plans, and was addressed to the problem that many pension plans relied on by employees for retirement income were rendered insecure and illusory by various questionable practices by the people administering the plans. Indeed, ERISA's title itself refers only to "retirement income security." 3/

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3 Thus, 29 U.S.C. section 1001 sets forth Congress' findings and declaration of policy. Subdivision (a) provides, in part:

> 1. "that despite the enormous growth in [employee benefit] plans many employees with long years of employment <u>are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans</u>";
>
> 2. "that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered";

The type of health care benefits involved at bar were an incidental, unconsidered form of compensation offered by some employees.

Nothing in the Congressional findings and declarations of policy even remotely reflect a Congressional intention to preempt state laws aimed at

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(Footnote 3 continued.)

> 3. "that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits"; and
>
> 4. "it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenues of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such [employee benefit] plans and their financial soundness." (Emphasis added.)

Subdivision (b) refers exclusively to reporting and disclosure requirements, which are obviously aimed at insuring the

protecting beneficiaries of medical, hospital or disability insurance contracts. To the contrary, these sections plainly and explicitly state that the "well-being and security of millions of employees and their dependents" is the primary purpose of ERISA. 29 U.S.C. section 1001, subdivision a. See also 29 U.S.C. section 1001a, subdivision (a)(3) and 29 U.S.C. section 1001b, subdivision (a((2).

It is therefore respectfully submitted that there is nothing to show

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(Footnote 3 continued.)
objective of adequate funding of ERISA employee benefit plans, and are peculiarly applicable to funding of retirement benefits. Their applicability to medical and hospitalization plans is marginal.

Subdivision (c) of 29 U.S.C. section 1001 refers only to private pension plans.

Congress also set forth further findings and declarations of policy 29 U.S.C. sections 1001a and 1001b. These sections refer solely to pension plans.

that Congress intended to nullify state laws which regulate insurance, particularly in view of Congress' explicitly stated intention to safeguard the "well-being and security of millions of employees and their dependents." 29 U.S.C. section 1001, subdivision (a).

II
THE UNITED STATES SUPREME COURT DECISIONS DO NOT REQUIRE AN INTERPRETATION OF ERISA PREEMPTION THAT WOULD RESULT IN A WHOLESALE NULLIFICATION OF ALL OF THE LAWS OF THIS STATE PROTECTING BENEFICIARIES OF HEALTH CARE INSURANCE.

As discussed above, the decision of the United States Supreme Court in Metropolitan Life Ins. Co. v. Massachusetts, supra, clearly supports the conclusion that ERISA preemption does not apply to any of the above-enumerated state laws enacted to protect beneficiaries of health care insurance,

including the Insurance Unfair Practices Act. That case states that there is a presumption against preemption of areas of "traditional state regulation" (471 U.S. at p. 740, 105 S.Ct. at p. 2389). The opinion further states that "we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope" (471 U.S. at p. 741, 105 S.Ct. at p. 2390). The Court rejected the contention that "Congress intended [a] narrow reading of the saving clause," 29 U.S.C. section 1144(b)(2)(A) (exempting from ERISA any state law which regulates insurance) (471 U.S. at pp. 745-746, 105 S.Ct. at p. 2392). See also 471 U.S. at pp. 746-747, 105 S.Ct. at p. 2393). It states that the saving clause if "broad on its face" (471 U.S. at p. 746, FN 24, 105 S.Ct. at p. 2393, FN 24).

Thus, the logical extension of

Metropolitan Life Ins. Co. v. Massachusetts would make it clear that it applies to the present case, where there is a specific state statute which on its face states that its purpose is to regulate insurance. Point III, infra. Indeed, the Fifth Circuit Court of Appeals in Pilot Life Ins. Co. v. Dedeaux, supra, relied on Metropolitan Life in concluding that even the common law cause of action for bad faith came within the saving clause (see Pilot Life, supra, 107 S.Ct. at p. 1551).

The Supreme Court in Pilot Life rejected that conclusion, based on the determination that the common law cause of action for bad faith did not regulate insurance because it was a state law of general application which is not specifically directed toward the insurance industry. 107 S.Ct. at pp.

1554-1555. However, Pilot Life did not address the situation where, as here, the applicable state law is specifically directed toward the insurance industry. See Point III, infra. The case before this Court is thus different from Pilot Life, just as the case before the Court in Pilot Life differs from that in Metropolitan Life. Pilot Life was not addressed to a situation such as the present situation. [4/]

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[4] The last portion of the Pilot Life decision (107 S.Ct. at pp. 1555-1558), with respect to the exclusivity of ERISA remedies, obviously only applies to actions to which the saving clause does not apply. Otherwise, it would almost entirely nullify the saving clause, and make superfluous the Court's previous detailed discussion as to whether the state law in question regulated insurance.

Thus, Pilot Life concluded with the statement that the state law suit is not saved by the saving clause and "therefore is preempted." (107 S.Ct. at p. 1558). Conversely, suits within the savings clause are not preempted and ERISA is

III
INSURANCE CODE SECTION 790.03(h) IS CLEARLY A STATE LAW REGULATING INSURANCE, AND AS SUCH IS EXEMPT FROM ERISA.

We respectfully submit that plain common sense demonstrates that Insurance Code section 790.03(h) is a state law regulating insurance and hence is exempted from ERISA by virtue of the saving clause, 29 U.S.C. section 1144(b)(2)(A). Insurance Code section 790.03(h) is a part of Article 6.5 of the Insurance Code, Insurance Code sections 790, et seq. It is clear that Article 6.5 was aimed and intended to come precisely within the provisions of the McCarran-Ferguson Act, 15 U.S.C. sections 1011, et seq. (providing that the business of insurance shall be subject to state laws which relate to the regulation

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(Footnote 4 continued.)
irrelevant to these suits.

of such business. See 15 U.S.C. sections 1011-1014).

Thus, Insurance Code section 790 specifically states that its purpose is "to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of March 9, 1945". The Act of Congress of March 9, 1945 is, of course, the McCarran-Ferguson Act.

Thus, there is no question but that our Legislature intended that Article 6.5 of the Insurance Code come within the McCarran-Ferguson saving provisions.

The saving clause in ERISA is interpreted in much the same manner as the saving clause in the McCarran-Ferguson Act. See Pilot Life, supra, 107 S.Ct. at pp. 1553-1554; Metropolitan Life Ins. Co. v. Massachusetts, supra, 471 U.S. 724,

743-744, 105 S.Ct. 2380, 2391. We therefore respectfully submit that it is clear that the provisions of Article 6.5 of the California Insurance Code are within the ERISA saving clause. See also: Federal Trade Commission v. National Cas. Co. 357 U.S. 560, 78 S.Ct. 1260 (1958) (state laws proscribing unfair insurance advertising [as does Article 6.5 of the Insurance Code--see Insurance Code sections 790.03(a) and (b)] constitute state regulation of the business of insurance as that phrase is used in the McCarran-Ferguson Act); Addrisi v. Equitable Life Assur. Society of U.S. (9th Cir. 1974) 503 F.2d 725, 728, cert. den. (1975) 420 U.S. 929, 95 S.Ct. 1129, rehearing den. (1975) 421 U.S. 922, 95 S.Ct. 1590, disapproved on other grounds, St. Paul Fire & Marine Ins. Co. v. Barry 438 U.S. 531, 98

S.Ct. 2923 (1978) (holding that Article 6.5 of the Insurance Code is a state law regulating the business of insurance).

The language of other provisions of Article 6.5 confirms that conclusion. In addition to the explicit language of California Insurance Code section 790, quoted above, Insurance Code sections 790.01 and 790.02 also recite that Article 6.5 applies to persons and practices "in the business of insurance".

Conversely, and unlike the situation in Pilot Life, the provisions of Article 6.5 do not apply to anyone who is not engaged in the business of insurance, and such persons or entities are not covered by the Act. See: Dill v. Claims Administration Services, Inc. 178 Cal.App.3d 1184 (1986); Richardson v. GAB Business Services, Inc. 161 Cal.App.3d 519 (1984); Wolfrich v. United Services

Automobile Ass'n. 149 Cal.App.3d 1206 (1983). Indeed, in Isaacson v. California Insurance Guarantee Association, supra, this Court reaffirmed that an entity must be in the business of insurance to be subject to California Insurance Code section 790.03(h), and limits such entities to those who issue policies, collect premiums, make profits and assume contractual obligations to insureds (44 Cal. 3d at p. 787).

We therefore respectfully submit that any "common-sense view" of the matter (see Pilot Life, supra, 107 S.Ct. at p. 1553) demonstrates that California Insurance Code section 790.03(h) is a law regulating insurance which is specifically exempted from ERISA.

Conclusion

The public policy of California requires that the detailed legislation enacted by our Legislature to protect those unfortunate citizens of this State who must receive extensive health care services should not be nullified by departing from the common-sense view of the language of the applicable statutes. Such an interpretation would have a seriously adverse effect on health care in this State.

Respectfully submitted,

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